Amendment to Plan of Benefits

For Employees of: The Department of Defense Nonappropriated Fund Health Benefits Program

Administrative Services Contract No.: ASC-721027

1. **Effective January 1, 2000, the following changes have been made to your Booklet.**

   A. If you are enrolled in the Managed Choice (POS) Plan, benefits for Covered Medical Expenses incurred for ambulance service will be paid at 80% for Preferred Care and at 80% after the deductible for Non-Preferred Care.

   B. The Medical Plan normally pays a lesser percentage of the fees charged for the secondary procedures when more than one surgical procedure is performed at one time or during a single operating session. Surgical preparation and other fees are included in the fee for the primary surgery.

   C. To be eligible for temporary continuation of coverage under the Health Expense Coverage disability provisions, the employee's attending physician must provide evidence of the disability to the *Employee's Human Resources Office (HRO). You must submit a doctor's statement as proof of total disability within 60 days of the date your medical coverage first terminated.

   *Army Air Force Exchange Service employee's attending physician must provide evidence of the disability to Aetna.

   D. The following paragraph is being added to the sub-section entitled "Claim Procedures for Health Expense Benefits" under the "Claim Appeals for Health Expense Benefits" section of your Health Expense Coverage:

   Benefits under this plan will be paid only if the plan administrator decides in his/her discretion that the applicant is entitled to them.

2. **Effective January 1, 2001, the following changes have been made to your Booklet.**

   A. If you are enrolled in either the Managed Choice (POS) Plan or the Open Choice (PPO) Plan, Preferred Care and Non-Preferred Care benefits for Covered Medical Expenses incurred for durable medical equipment will be paid at 80%. A deductible will not apply.

   B. The provision that describes the general rules for determining reduced benefits in the sub-section entitled "Other Plans not including Medicare" under the "Coordination of Benefits" section of the Health Expense Coverage is replaced with the following:

   The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claims transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. A "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

C. The provision that describes the general rules for determining reduced benefits in the sub-section entitled “Other Plans not including Medicare” under the “Effect of Benefits Under Other Plans” section of the Dental Expense Coverage is replaced with the following:

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claims transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. A "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

3. Effective March 28, 2001, the following changes have been made to your Health Expense Coverage and Dental Expense Coverage Booklet.

The following is added to the section entitled “Effective Date of Coverage” of the Summary of Coverage:

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage will not apply to affect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective; provided you make written request for such coverage within 31 days of the court order. Coverage for the child will become effective on the date of such court order. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

4. Effective January 1, 2002, the following changes have been made to your Booklet.

A. The following is added to the section entitled "Benefits" of the Dental Expense Coverage:

The benefits payable for charges made by a Preferred Care Provider is an amount equal to the Payment Percentage of the negotiated charge for the service or supply, after any applicable deductible.

The benefit payable for charges made by a provider that is not a Preferred Care Provider is an amount equal to the Payment Percentage of the Covered Dental Expense, after any applicable deductible.

The Plan will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses. You are responsible for the deductible.

The following definitions are added to the Dental Expense Coverage Glossary:

Directory

This is a listing of all Preferred Care Providers for the class of employees of which you are a member. Copies of this Directory can be requested by calling the Member Services number on the front of your ID card. A listing of the Preferred Care Providers is also available at the Aetna DocFind® internet website. The Aetna internet home page address is listed on the back of your ID card.

Negotiated Charge

This is the maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

B. The section entitled "Prescription Drug Coverage" in the Summary of Coverage of the Health Expense Coverage is replaced by the following:

Prescription Drug Coverage

When the prescription is purchased through:	**And the prescription is for a "generic" drug, the expense is covered at:**	**And the prescription is for a "brand-name" drug listed on the medication formulary, the expense is covered at:**	**And the prescription is for a "brand-name" drug <u>not</u> listed on the medication formulary, the expense is covered at:**
Mail Order Pharmacy - Express Pharmacy Services *****	100% after a $10 copay per prescription or refill for up to a 90-day supply	100% after a $20 copay per prescription or refill for up to a 90-day supply	100% after a $30 copay per prescription or refill for up to a 90-day supply
A Participating Pharmacy	100% after a $10 copay per prescription or refill up to a 30-day supply	100% after a $20 copay per prescription or refill up to a 30-day supply	100% after a $30 copay per prescription or refill up to a 30-day supply
A Non-Participating Pharmacy in the US	No Coverage	No Coverage	No Coverage
Overseas Pharmacies	100% after deductible	80% after deductible	80% after deductible

* The Mail Order Pharmacy feature of the Prescription Drug Benefit is designed to be used by individuals using maintenance type medication for the treatment of chronic or long-term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure, for periods of 30 days or longer. This program covers any prescription drug covered by the Plan.

Copayments as listed above are to be paid at the Participating Pharmacy at the time of purchase. No other prescription drug benefits are payable. Do not submit prescription drug claims for prescription drugs obtained in the U.S.

Refills for prescription drugs will be filled in accordance with the terms of the Plan, provided that:

- *for a 10 to 30 day supply at least 50% of the prior prescription or refill has been used; or*
- *for a supply greater than 30 days at least 75% of the prior prescription or refill has been used; or*
- *for a supply furnished by a **mail order pharmacy** at least 60% of the prior prescription or refill has been used.*

The date of the most recent prescription or refill will be used to determine the percentage used.

C. The following definition is added to the sub-section entitled "An Explanation of Certain Terms" under the "Prescription Drug Expense Coverage" section of your Health Expense Coverage:

Medication Formulary. A listing of prescription drugs which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both brand name drugs and generic drugs and is subject to periodic review and modification by Aetna. Call the Aetna Customer Service number on your ID card for information.

D. If you are enrolled in the Managed Choice (POS) Plan, benefits for Covered Medical Expenses incurred for *Hospital Expenses* under the Comprehensive Medical Expense Coverage section of the Health Expense Coverage in the Summary of Coverage is replaced by the following:

Hospital Expenses	**Preferred Care**	**Non-Preferred Care**	**Out-of-Area Dependent Care**
Bonafide Emergency Room Treatment	100% after a $ 100 Emergency Room copay per visit*	100% after a $ 100 Emergency Room deductible per visit*	80% after deductible
Non-emergency use of the Emergency Room	50% after a $ 100 Emergency Room copay per visit	50% after a $ 100 Emergency Room deductible per visit	50% after deductible
Surgery Expenses	90% no copay	70% after deductible	80% after deductible
Board and Room	90% after $200 inpatient per confinement fee	70% after $400 inpatient per confinement fee	80% after deductible
Other Hospital Expenses	90% no copay	70% after deductible	80% after deductible

*These amounts are waived if a person becomes confined in a hospital.

NOTE: The Private Room Limit is the institution's **semiprivate rate** (private rate if a private room is medically necessary).

E. If you are enrolled in the Open Choice (PPO) Plan, Hospital Expenses incurred for emergency care provided by a **Non-Preferred Care Provider** or a **Preferred Care Provider** will be paid at 100% after a $100 Emergency Room Deductible or Copay is satisfied. If admitted, the Emergency Room Deductible or Copay will be waived.

F. If you are enrolled in the Open Choice (PPO) Plan, benefits for Covered Medical Expenses incurred for *Hospital Expenses* under the Comprehensive Medical Expense Coverage section of the Health Expense Coverage in the Summary of Coverage is replaced by the following:

Hospital Expenses	**Preferred Care**	**Non-Preferred Care**
Second Surgical Opinion	100% no deductible, no copay	100% no deductible
Preoperative Testing	90% no deductible	70% no deductible
Laboratory & Diagnostic X-rays	90% no deductible	70% after deductible
Inpatient Surgery Expenses	90% no deductible, no copay	70% after deductible
Outpatient Surgery Expenses (including Birthing Center)	90% after deductible	70% after deductible
Independent Laboratory & Diagnostic X-rays	90% after deductible	70% after deductible
Physician's Expenses in the Hospital	90% after deductible	70% after deductible
Other Hospital Expenses	90% after deductible	70% after deductible

G. If you are enrolled in the Managed Choice (POS) Plan, Preferred Care benefits for Specialist Office Care will be paid at 100% after a $25 copay per visit.

The following definition is added to the Managed Choice (POS) Plan Glossary:

Specialist
A **physician** who:

- is a **preferred care provider**; and
- is not a **primary care physician**.

H. If you are enrolled in the Open Choice (PPO) Plan, Preferred Care benefits for Specialist Office Care will be paid at 100% after a $25 copay per visit.

The following definitions are added to the Open Choice (PPO) Plan Glossary:

Primary Care Physician
For purposes of applying this plan's **copay** provisions, a **Primary Care Physician** is a **Preferred Care Provider** who is an internist, pediatrician, family practitioner or general practitioner.

Specialist
For purposes of applying this plan's **copay** provisions, a **Specialist** is a **physician** who:

- is a **preferred care provider**; and
- is not a **primary care physician**.

I. If you are enrolled in the Traditional Choice (Indemnity) Plan, benefits for Preoperative Testing Expenses will be paid at 80% with no deductible.